DENTAL BOARD OF CALIFORNIA

Authorization for Release of Dental/Medical Patient Records

Patient Name:_____ Date of Birth:_____

AUTHORIZATION TO RELEASE INFORMATION: I, the undersigned, authorize any physician, dentist, medical practitioner, hospital, clinic or other dental or dental related facility having records (original and/or electronic) available as to diagnosis, treatment and prognosis with respect to any dental or medical condition and/or treatment of me (or the patient) to release to the Dental Board of California or any Board representatives, related local, state and federal governmental agencies, including but not limited to, investigators and legal staff.

I understand that this information will be maintained in confidence, and will be used solely in conjunction with any investigation and possible legal proceeding regarding any violations of California laws and regulations. I further agree to allow the Board, Board representatives and related governmental agencies, to process and possibly file other charges based on my complaint.

I also understand that the subject of my complaint (the dentist or dental auxiliary I am complaining about) may receive a copy of my complaint and records pursuant to the Administrative Procedures Act and the Information Practices Act.

I agree that a photocopy of this Authorization shall be as valid as the original. This Authorization shall remain valid until the Dental Board of California or other authorized Government Agency completes its review and the proceedings arising out of the investigation.

I understand that I have a right to receive a copy of this authorization if requested by me.

Patient/Guardian
Signature:_____Date:_____

Attach written proof of authorization to act on patient's behalf.

This release is in compliance with the requirements of Civil Code § 56.11.